ANGELO STATE UNIVERSITY NURSING PROGRAM
FACULTY IMMUNIZATION RECORD

Name:____ CID:____________________

Current Mailing Address:____

City: ____ State:________________ Zip:___________

Daytime Phone:______________________ Date of Birth:________________________

Program: (Please Check One) ☐ **Generic BSN** ☐ **MSN**

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IMMUNIZATION HISTORY

Must be completed by a physician or health care facility official AND signed at the bottom of this form.
Immunization records **MUST** accompany this form.
DO NOT SUBMIT BLANK FORM WITH RECORDS ATTACHED

Hepatitis B

3 doses of vaccine **AND** a positive titer (quantitative HBsAB >10mIU/ml) drawn 1-2 months after completion of the series

Vaccine #1__________Date (0mo)
Vaccine #2__________Date (1mo)
Vaccine #3__________Date (6mo)
Date of Titer: ________Results: _________ (1-2 months after last dose)

Negative titer after 3 dose series - repeat the 3 dose series booster **AND** titer
Booster vaccines

Vaccine #1__________Date (0mo)
Vaccine #2__________Date (1mo)
Vaccine #3__________Date (6mo)
Date of Titer: ________Results ________(1-2 months after last dose)

Negative titer after 1 dose booster - complete the remaining 2 vaccines in the series then a titer

Date of Titer: ________Results ________(1-2 months after last dose)

Negative titer after 2nd 3 dose series - provide one of the following:

Documentation of counseling provided from a medical provider for non-responder status **OR**
Documentation from a healthcare provider of other immunity to Hepatitis B.
Date of required documentation: _____________

*Missing documentation: *Even if you have a positive titer*, complete the doses you are missing documentation on, or the whole series if needed, then complete the titer 1-2 months after the last vaccine.

**Completed only part of the series: *Even if you have a positive titer*, complete the vaccines you are missing in the series then complete the titer 1-2 months after the last vaccine.

***Completed the series, have documentation, but never had a titer drawn:

Complete a titer. If negative, obtain a one dose booster of vaccine, REPEAT titer.
2nd Negative titer -complete the final 2 doses of the series, REPEAT titer.
3rd Negative titer - see Negative titer after 2nd 3 dose series above.

Tetanus-Diphtheria-Pertussis (Tdap) and Tetanus and Diphtheria (Td)

Date of Tdap Vaccine (within the past 10 years):___________
Date of Td Vaccine (required 10 years after Tdap and every 10 years thereafter):__________

MMR (Measles, Mumps, Rubella):

2 doses of MMR vaccine on or after the 1st birthday separated by 28 days or more – no titers required

Date of MMR Vaccine #1_________

Date of MMR Vaccine #2_________

OR

2 doses of Measles (separated by 28 days or more), 2 doses of Mumps (separated by 28 days or more) and 1 dose of Rubella, (all after the 1st birthday) **OR** serologic proof of immunity for Measles, Mumps and/or Rubella

Date of Measles Vaccine #1__________ **OR** Date of Titer: __________ Results _______

Date of Measles Vaccine #2__________

Date of Mumps Vaccine #1__________ **OR** Date of Titer: __________ Results _______

Date of Mumps Vaccine #2__________

Date of Rubella Vaccine #1 __________ **OR** Date of Titer: __________ Results _______

Varicella (Chicken Pox)

2 doses of varicella vaccine given at least 28 days apart **OR** IgG titer

Date of Varicella Vaccine #1____________ **OR** Date of IgG (titer): ___________Results __________

Date of Varicella Vaccine #2____________

Influenza

1 dose annually at the beginning of flu season (September/October)

Date of Flu vaccine:___________ Date of Flu vaccine_____________ Date of flu vaccine________________

Tuberculosis Screening

2 negative TB skins tests (TST) then **annual** TST **OR** negative blood test (IRGA) then **annual** IGRA. *****History of positive TST or IGRA*

Negative TST within the last year

Date of TST #1 ________ (within the last year) Results: ________

Date of TST #2 ________ (current test) Results: ________

Never had a TST or TST > than 1 year ago

2 Step Skin Test

Date of Skin Test #1 _______(initial test) Results: ________

Date of Skin Test #2_______ (7-21 days from test #1) Results: ________

OR

TB Blood test (IGRA) within the last year

Date of IGRA _________ Results: ________

OR

*****Positive TST or positive IRGA*?

1. **Provide documentation** of initial evaluation by a healthcare provider including: any treatment completed and negative chest x-ray. Date treatment Completed __________ Results of CXR:____________
2. Current TB screening questionnaire by healthcare provider (within the past year). Date: _______________

Annual TB questionnaire screening by a healthcare provider is required.

FOR INTERNAL USE ONLY
Date of annual TST _________ Results ___________
Date of annual TST _________ Results ___________
Date of annual TST _________ Results ___________
Date of annual IRGA ________ Results ___________
Date of annual IRGA ________ Results ___________
Date of annual IRGA ________ Results ___________

FOR INTERNAL USE ONLY
Annual TB screening questionnaire Date____________ Date _____________ Date______________ Date_________________

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PHYSICIAN/HEALTH CARE FACILITY INFORMATION

TO THE PHYSIAN/HEALTH CARE OFFICIAL: This form will not be accepted if the below information is not completed and signed.

Physician/Provider Name (Print):____

Signature:________________________________ Title:__________________________

Address:______________________________ City:______________ State:_______ Zip:_______

Date:_________________________ Phone:_________________________